U.S. Immigration and Customs Enforcement

ICE Health Services Corps (IHSC)
Enforcement and Removal Operations
Immigration and Customs Enforcement

# Root Cause Analysis Guide

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## Foreword

This IHSC Root Cause Analysis Guide supplements the following IHSC Directives:

11-02, *Quality Improvement and Risk Management*

11-06, *Time Frame for Submitting Medical Incident Reports*

This Guide explains concepts, assigns responsibilities and details procedures for performing a Root Cause Analysis.

The intended audience is IHSC Federal staff in the field and health staff who conduct Root Cause Analyses.

## I. Root Cause Analysis

**Root Cause Analysis (RCA)** – RCA is the process for identifying the basic or contributing causal factor(s) associated with adverse and/or sentinel events. The review is interdisciplinary and includes those who are closest to the process. It identifies changes that could be made in systems and processes to improve performance, promote positive outcomes, and reduce the risk of adverse events or recurrence of close calls. The RCA process helps to identify what, how and why an event occurred.

## II. Identifying the Root Cause Analysis Team

A. **The Root Cause Analysis Team (RCAT)** – The RCAT should consist of persons familiar with the event, as well as subject matter experts (as appropriate), having knowledge of the event, and at least one representative from IHSC-Medical Quality Management (MQM) Unit in Headquarters. The team is not limited to clinic staff and should include representation from any other stakeholders.

B. The team consists of qualified federal medical employees (PHS or GS).

C. The RCAT should not consist of individuals directly involved in the event. They should be interviewed by the Health Services Administrator (HSA), and provide information or statements to the HSA on the event.

D. If an on-site internal IHSC review is requested by the MQM Unit Chief and authorized by the IHSC Assistant Director (or designee), the designated MQM Unit-Compliance Investigation Unit (CIU) clinical investigator/fact-finder is included on the RCAT.

E. All members of the RCAT must have a signed confidentiality statement filed with the Quality Improvement Coordinator.

## III. Root Cause Analysis Process

A. The HQ Risk Management Team will meet to discuss the sequence of events from an incident and decide if an RCA is warranted. A member of the HQ Risk Management Team is appointed as lead for the RCA. This person is responsible for :

Educating/guiding the RCAT about the process;
Facilitating the RCA process in collaboration with the HSA
Arranging team meetings;
Ensuring all RCA documentation is completed by the facility RCAT and retained in a secure location;
Ensuring the RCA is completed within 45 business days from the date of the event (or discovery of the event); and

Providing the final report to the MQM Unit Chief and the IHSC Assistant Director (or designee) by the required completion date.

B. The RCA lead informs the HSA that an RCA is warranted after a preliminary review of the sequence of events. The RCA lead and the HSA gather the subject matter experts for the RCA. The RCA must be completed within 45 business days from the date of the event.

C. If an RCA is warranted and related to mortality, the RCA team (or assigned RCA Lead) will discuss with the CIU investigator assigned to case and attend the CIU meeting. When attending this meeting, the assigned RCA Lead will be prepared with questions and have reviewed the Sequence of Events (SOE).

D. If an RCA is warranted and not related to mortality, the RCA team (or assigned RCA lead) will schedule a meeting with the facility (local RCA team) to discuss the event. When attending this meeting, the assigned RCA Lead will be prepared with questions and have reviewed the SOE.

   The RCA meeting with the facility is to recommend improvement and measurement strategies to the facility. In addition, this opportunity will be used to provide applicable training and improve understanding of both system risk and behavioral risk.

   In the event the Investigators are activated, the first meeting is with the investigator to share their fact finding results with leadership and subject matter experts.

   If Investigators are not activated, the first meeting of the RCA is designated as the fact finding session. In this session, the sequence of events is reviewed along with the use of the '5 Why's' Iterative question-asking technique to explore the cause and effect relationships underlying the problem. – See Figure 1A—The 5 Why's Steps – page 7

   The second session is designated to developing and implementing corrective action plans based on the first session's findings. At the end of this session, concrete timelines and data collection points are identified. – See Figure 1A—The 5 Why's Steps

E. If there is a need for additional clarifications, the assigned RCA Lead will contact the facility Point of Contact (HSA/AHSA).

F. After the facility submits the completed RCA, the assigned RCA Lead will discuss with the HQ Risk Management Team to ensure the appropriate plan of action has been established and determined if any additional clarification is needed before finalizing. The RCA Lead will submit the RCA within one week of the RCA

Team's final approval recommendations. S:\IHSC\Medical Quality Management\RCA Sentinel Events\DIHS-020 Root Cause Analysis Report.pdf

G. The Risk Management RCA Lead forwards the completed RCA form (blank form available on the shared drive), using the routing slip, to the OHA-MQM Unit Chief and IHSC-MQM Unit Chief for review prior to submission to the Associate Director, Deputy Assistant Director for Administration, Deputy Assistant Director for Clinical Services (or designee) and Health Operation Unit Chief of IHSC within 45 business days of the incident/event.

H. The third session of the RCA occurs six months after the close-out of the root cause analysis. The purpose of this session is to evaluate the documentation and the results of the action plan and discuss any additional suggestions by the committee. The facility leadership provides documentation and evidence to support that the improvement and measurement strategies identified during the RCA process were implemented.

## IV. References

A. Clinical Incident Management Toolkit, *Delivering a Healthy WA*, DOH 2011

B. Performance Improvement Plan, Chapter 5, pg. 12; April 2005

C. Medical Quality Management Directive; DHS MD Number 248-01 (October 2, 2009).

D. Medical Quality Management Instruction; DHS Instruction Number 248-01-001 (September 10, 2012).

# The 5 Whys- Steps—Figure 1A

| STEP 1 | Step 2 | Step 3 | Step 4 | Step 5 |
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| **Gather Information** | **Determine the Sequence of Events** | **Determine Points of Variation – Contributing Factors** | **Develop Recommendations** | **Monitor Implementation of Recommendations** |
| Documentation and material related to the incident should be collected as soon as possible:<br><br>Ensure information is available for use in the investigation<br>Allow development of a description of the sequence of events leading up to the incident | Develop a chronology of events based on all the information gathered<br><br>RCA team agree on the chronology of events | Complete a comparison between what actually happened with what should have happened<br><br>Reference policies and procedures and review of current literature may help assist in this analysis | Recommendations are developed for actions to address each of the contributory factors.<br><br>Recommendations are considered strong if they are highly likely to reduce risk by making it very easy for staff to do the right thing.<br><br>Ensure the recommendations are measureable. | The Implementation of Recommendations should be monitored.<br><br>Positions should be assigned responsibility for implementing recommendations<br>Verify the frequency of reporting requirements |
| Information that may be relevant includes:<br><br>Patient health records from all service providers involved (e.g.) emergency medical services, community providers<br>Relevant policies and procedures<br>Relevant physical evidence | Document the sequence of events leading up to the incident or near miss | For each point where actual events deviated from expected events ask the question 'Why' five times (or more if necessary) until the basic contributory factors are identified<br>Some contributory factors are likely to | Strong recommendations include those that:<br><br>Introduce a forcing function (e.g. a unique connectors to allow only correct assembly of equipment)<br>Remove the opportunity to do the wrong thing (e.g. remove all potassium chloride from wards)<br>Standardize to reduce confusion (e.g. purchase only | |

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| (medications, packaging, equipment)<br>Observations and comments from staff involved<br>Comments and information from the patient and family members as appropriate<br>Information about the environment and conditions (e.g. staff roster) | | be present in future situations (e.g. medication labels of similar color and design) and some are likely to have been specific to the event under investigation (e.g. a one off communication problem between staff) | one type of IV pump for a hospital).<br>Simplify processes<br>Introduce a physical barrier to prevent harm (e.g. non slip floor coverings, bed rails)<br>Remove a hazard (e.g. fix or replace equipment) | |
| Observation and comments from staff involved, e.g. written statements, interviews should focus on their recollection of the SOE and timing of events, their involvement and any difficulties or problems they experienced or observed<br><br>If an on-site review is conducted by the MQMB-CIU the CIU investigator is the principal fact finder for the RCAT and provides all relevant information to the other members of the | | Some investigations may identify gaps or issues that did not impact on the specific event under consideration but have the potential to contribute to adverse events in the future. These issues should be recorded and considered in the development of recommendations (e.g.) HFMEA | Examples of intermediate actions used for the development of recommendations include:<br><br>The use of checklists, protocols and reminders (cognitive aids) to reduce reliance on memory<br>The elimination the use of 'sound-alike or look-alike' names<br>Increase staffing/decrease workload<br>Enhancement/modification of software<br>Improvements in documentation/communication /handover<br>Elimination/reduction in distractions | |

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| RCAT for review | | | | |
| | | Contributing Factors may include:<br><br>Patient Factors: condition, language and communication, personality and social factors<br><br>Task and Technology Factors: availability and use of protocols | Examples of weak recommendations-ideas those are less likely to reduce risk. Weak recommendations include:<br><br>Rely on documentation that may be difficult to access or compete with other information (e.g. policies and procedures)<br>Rely on training that may take time to provide to all necessary parties and may not be retained fully | |
| | | Individual Staff factors: physical and mental health competency<br><br>Team Factors: verbal and written communication<br><br>Work Environment: staff levels and skill mix<br><br>Organizational and Management Factors: financial resources and constraints, policy. | Considerations to consider:<br><br>If the RCA team finds that the best possible care has been provided, there may be no recommendations for this action.<br>The RCA team develops concrete timelines, data collection points, and positions responsible for implementing recommendations | |

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| | | Standards and goals, safety culture and priorities<br><br>Institutional Context Factors: facility security policies and context | | |